Wyoming Mental Health Division

Pre-Approval for Modification to Children's Mental Health Waiver Service Plan

Name of Youth: _____ Medicaid ID # 06-_____

Plan Date: _____ Family Care Coordinator: _____

Requested Modification Effective Date: _____

Service Code	Service Type	Service Provider Number (9 digits)	Provider Name	Units to be Used (3 months)	Unit Rate	Total Cost (3 months)
					TOTAL	**$**

_____ _____

Signature of Parent/Guardian/Responsible Person Date

_____ _____

Signature of Family Care Coordinator Date

☐ Approved by MHD _____ _____

Signature Date

Form #: FCC-3
Implementation Date: 7/1/06 Revision Date: None